NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

LB 1083
Behavioral Health
Implementation Plan

Executive Summary

July 1, 2004

I. Executive Summary

A. Overview

On April 14, 2004, Governor Mike Johanns signed into law Legislative Bill 1083, the Nebraska Behavioral Health Systems Act. Introduced by Senator Jim Jensen, this historic legislation reforms Nebraska's behavioral health services by moving from an over-reliance on state-owned Regional Centers to creation or expansion of acute inpatient, secure residential and support services in the community. LB 1083 provides services closer to home and in the least restrictive, appropriate setting while accessing federal Medicaid dollars.

HHSS will partner with the Behavioral Health Regions, community-based providers, mental health consumers, and other stakeholders to ensure that the implementation plan is comprehensive and includes local recommendations on what services are needed. In Phase I, as HHSS looked at the needs of Nebraska as a whole, HHSS worked diligently with the Regions to develop their Phase I recommendations.

LB 1083 creates the Division of Behavioral Health Services within the Department of Health and Human Services (HHS). The new division will ensure that the necessary array of services is available and that placements are appropriate for each behavioral health consumer.

The legislation requires that appropriate community-based services be available before Regional Centers are closed. When the Regional Centers reach 20 percent of their licensed psychiatric bed capacity as of March 15, 2004, HHSS will notify the Legislature and the Governor. A majority vote by the Executive Board of the Legislative Council will allow for transfer of the remaining patients when appropriate community-based services are available.

Because a high percentage of the commitments to the Norfolk and the Hastings Regional Centers come from Region VI, a facility is being planned for the Omaha metropolitan area. It is referred to in the plan as the Community Resource Center (CRC). The purpose of the Community Resource Center is not to substitute Regional Center beds, but to build an array of services that provide alternatives to long-term Regional Center placement, to support mental health research and to provide education to health care professionals in training. Private funding is being sought to create the CRC in either a new or an existing building. The CRC will be a community hospital, not a Regional Center, and, therefore, eligible to received Medicaid funds.

This reform plan includes a collaborative effort between the medical centers at Creighton University and the University of Nebraska to provide behavioral health training, research, and clinical services and a program to provide professionals to serve rural Nebraska. This critical partnership will enable Nebraska to move to a prominent position as a leader in mental health service delivery and a model of statewide recovery-based services.

LB 1083 also creates a Behavioral Health Oversight Commission of the Legislature to oversee and support implementation of the Act. Senator Jim Jensen announced membership of that Commission in June 2004, and the Commissions' first meeting is scheduled for July 9, 2004.

HHSS provided information or briefings to a wide variety of individuals and organizations that have an interest in the behavioral health system. The extensive involvement of those stakeholders in planning, problem solving, and decision-making will continue as a key component of Behavioral Health Reform. Stakeholders include those individuals effecting the change, as well as those impacted by it.

This plan focuses on two core values central to the implementing legislation: 1) Citizens in need of behavioral health services will receive more appropriate care; and 2) the new behavioral health system will make better use of scarce resources.

Citizens needing behavioral health services receive more appropriate care
LB 1083 will provide more appropriate services for people with behavioral health issues. Consumers will be served closer to their home communities, and live more independent lives with more support. They will be closer to their health care providers, support groups, family and friends in the least restrictive environment that still provides safety and protection for the individuals and the community.

The Behavioral Health Reform focus is on people who would have been served at a state-owned Regional Center – persons committed by Mental Health Commitment Boards for involuntary treatment. Approximately 700 individuals are committed to the Hastings and Norfolk Regional Centers each year.

LB 1083 addresses the lack of behavioral health services once individuals no longer need the hospital-based inpatient services provided at Regional Centers or local hospitals. The new community-based system will include many levels of services. Consumers requiring crisis stabilization will access enhanced crisis center services. Community hospitals throughout the state will be able to develop acute psychiatric inpatient and secure residential services with the capacity to have locked units and highly trained staff. Residential rehabilitation services are less restrictive and more appropriate for some persons. Other non-residential community programs can provide services and reduce re-hospitalization. Regional Center beds will stay in place for individuals with high needs, and to provide specific care, such as the sexual offender and forensic programs.

HHSS has partnered with each of the Behavioral Health Regions to ensure that appropriate community-based services are in place statewide. Community-based services may range from intensive, hospital-level care to a secure, specialized wing of a nursing home, other residential facility, or day treatment program.

Better use of scarce resources
Behavioral Health Reform creates new, additional funding to invest in a wider array of community-based behavioral health services. Moving services from the Regional Centers into the community makes it possible to leverage state general funds to access approximately $9 million in previously unavailable federal funds. Funding of approximately $29 million annually for inpatient care at the Hastings and Norfolk Regional Centers will be redirected to fund statewide community-based services.

Funding for the Reform will include $6 million in one-time funding to fund parallel systems during the transition. Another $2 million will be available annually for rental assistance for consumers moving from Regional Centers to the community and for construction of suitable housing. An additional $2.5 million in annual funding for emergency services is more than doubles the amount formerly available.

B. LB 1083 Implementation Plan

Focus Area One – Behavioral Health Region Plans: Phase I

The first section of the Behavioral Health Implementation Plan outlines the development of services and necessary funding for each Region of the state. The six Behavioral Health Regions assessed the needs of each Region and submitted plans on March 30, 2004 to meet those needs through community-based services. The Nebraska Department of Health and Human Services System compiled and refined the regional plans to maximize resources from a statewide perspective and match the services with the specific needs of the consumers served by Regional Centers.

The funding is allocated based on the anticipated costs associated with the specific types of services needed to meet the Phase I priorities in each Region of the state. Additionally, the funding level is influenced by the average length of time a service is needed by the consumer. Phase I priority service development and funding is as follows:

In Region I, the Panhandle, reliance on Regional Center care is minimal with 93% of mental health board commitments served by hospital level community based services and coordination of services provided by the Homeward Bound Project. Behavioral health services to be expanded include adding crisis response services for communities not currently served by Local Crisis Response Teams, increasing emergency crisis capacity and providing assisted living support services at a cost of approximately $1.1 million dollars.

In Region II, west central Nebraska, reliance on Regional Center care has been moderate with all persons committed within the last 4 months served at local hospital level community based services. Local crisis response services will be expanded, as will residential services and supportive services at a cost of $1.6 million.

In Region III, south central Nebraska, reliance on Regional Center care has traditionally been heavy as the region has the highest per capita commitment rate in the state. Existing hospital-level community-based services, community residential, support services and an emergency crisis stabilization unit will be utilized to serve consumers at a cost of approximately $4 million (including one time start up costs). This shift in services is projected to decrease commitments and increase services being provided in the community.

In Region IV, a large geographic area in northeast and north central Nebraska containing mainly rural/frontier counties, heavy reliance on the Norfolk Regional Center traditionally has been the case. Additional acute and secure services at the community hospital level will be developed in addition to expanding residential and support services. Furthermore, crisis stabilization to serve about 50 persons and rural crisis response teams to serve 160 persons will be developed at a cost of approximately $3 million.

In Region V, southeast Nebraska, reliance on Regional Center acute, secure, and long-term residential services for the difficult to serve population, has generally been heavy. The Region annually serves approximately 220 consumers committed to acute and/or secure services and provides emergency protective custody (EPC) involuntary crisis stabilization services to over 800 consumers. The region has 24% of the population in the state with 31% of the state's EPC cases. Approximately 30% of committed individuals come from rural Region V. In Phase I,

Assertive Community Treatment (ACT) team services (capacity of 70), will be developed and directed towards consumers discharged from the Regional Centers. The emergency system will be expanded by funding rural emergency crisis response teams and emergency support services. Phase I services will cost approximately $1.4 million.

In Region VI, eastern Nebraska, the development of a Community Resource Center (CRC) will be the primary focus to co-locate emergency services and acute inpatient and secure subacute services. In FY03 Region VI committed 185 people to the Norfolk Regional Centers which constituted 75% of the commitments to that facility. 48% of commitments could have been served at a secure subacute level of care that is not currently available in Region VI. The CRC will provide a twenty-four hour emergency crisis center designed to further reduce the reliance on commitments for Regional Center services. Existing services and funding will be realigned and combined with expanded funding for the CRC. The creation of an additional Assertive Community Treatment (ACT) team, serving up to 70 consumers, will provide expanded community based treatment, rehabilitation and support services for the long-term hard to serve population from the Regional Centers. Phase I services will cost approximately $6 million.

Because the largest infusion of dollars into community-based services will result from the transition of Regional Centers and the dates of transition depend on the Centers reaching 20% of acute/secure capacity, it is not yet known when the redirection of Regional Center funds will occur. Therefore, the funding allocation plan is laid out in six scenarios.

The six options are found in the *Project Schedule: Balancing Intent, Schedule and Budget* section of the Implementation Plan. These examples show how the amount of funding available for the development of community based services decreases the longer services are provided in a Regional Center setting.

Focus Area Two: HHSS Plan to Implement LB 1083

The second focus area of the Behavioral Health Implementation Plan outlines the responsibilities of the Nebraska Health and Human Services in carrying out the behavioral health reform.

After passage of LB 1083, HHSS began reviewing internal changes or processes that needed to be in place in order to complete the implementation plan and support future activities. HHSS established eleven internal work teams: Regional Center Transition, Community Services, HHSS Organization, Employment, Housing, Finance, Human Resources, Strategy, Information/Payment, Communications and Academic Support.

HHSS developed a project plan to implement LB 1083. The implementation plan sets out specific details on what work HHSS must accomplish in order to improve the lives of consumers who would otherwise receive treatment in Regional Centers.

HHSS followed the core principles of project management methodology to ensure that this major work effort is carried out effectively.

The HHSS project plan identifies 108 actions/steps called deliverables that must be completed in order to achieve the Reform. The deliverables are supported by 494 individual steps called activities that must be completed in order to attain the deliverables. Finally, there are sixteen milestones identified in the project plan that gauge overall progress.

Sections 19 and 20 of LB 1083 establish specific requirements for this portion of the implementation plan. Therefore, the project plan is laid out to the corresponding section of the bill with a person responsible for each entry.

Conclusion:

This plan sets out the approach HHSS took in planning for Behavioral Health Reform, the scope of the implementation plan, and the specific activities that HHSS will undertake to accomplish reform. The details of the work make it clear that LB 1083 will result in more appropriate behavioral health services for people through a better use of scarce resources.